LIVE EVENT

Posttraumatic Stress Disorder

Changing the Perspective of Primary Care

MODERATOR

Brian Doyle, MD, CM
Clinical Professor of Psychiatry and Family and Community Medicine
Georgetown Medical School
Washington, DC

PANELISTS

Edna B. Foa, PhD
Director, Center for the Treatment
and Study of Anxiety
Professor of Clinical Psychology in Psychiatry
University of Pennsylvania
Philadelphia, Pennsylvania

Terence M. Keane, PhD
Professor of Psychology and Psychiatry
Boston University School of Medicine;
Director, National Center for Posttraumatic
Stress Disorder
Boston Veterans Administration Medical Center
Boston, Massachusetts

Randall Marshall, MD
Assistant Professor of Clinical Psychiatry
Department of Psychiatry
Columbia University
New York, New York

"At one time, we thought that posttraumatic stress disorder [PTSD] was quite a rare problem and therefore not of much interest to the general medical practitioner. But the current figures show that it is much more common than we once thought," said Brian Doyle, MD, CM, who is Clinical Professor of Psychiatry and Family and Community Medicine at Georgetown Medical School in Washington, DC, at the opening of a recent ***Medical Crossfire*** on PTSD in primary care. "The current estimates are that 40% to 90% of persons in the general population will be exposed to at least one trauma during the course of their lives, and up to 25% of those will develop PTSD," he noted.[1] Despite the frequency of trauma and PTSD, this disorder is still generally underdiagnosed for reasons that include high rates of comorbidity, patient denial or minimization, excessively high diagnostic thresholds on the part of clinicians, and, perhaps most important, failure to take trauma histories.[2] Thus, Dr. Doyle emphasized that it is very important for primary-care physicians to ask about traumas, to understand PTSD, and to be able to diagnose it effectively.

Epidemiology of PTSD

PTSD, A Common Disorder

"Early epidemiological studies reported very low rates of PTSD [1% in the Epidemiologic Catchment Area Survey],[3] but more recent studies with more modern methodologies have found considerably higher rates. It's not that we're having an epidemic, it's that we've become better at assessing it," explained Randall Marshall, MD, who is Assistant Professor of Clinical Psychiatry in the Department of Psychiatry at Columbia University in New York, New York. He noted that, "the key improvement, in terms of detecting it, was asking specifically about trauma, and that is probably the best approach for primary-care physicians as well."

PTSD is estimated to affect 2% to 5% of the general population[4] and to have a lifetime prevalence of 7.8%.[5] In primary-care populations, however, the prevalence is much higher. In one report, 11.8% of a primary-care population met criteria for full or partial PTSD.[4] Affected patients had high rates of comorbid major depression (61%), generalized anxiety disorder (39%), and substance use (22%). PTSD patients reported more functional impairment than did patients without mental disorders and had high rates of recent health care utilization. Left untreated, PTSD is frequently a chronic, debilitating illness, with one-third of people who have an index episode of PTSD failing to recover even over many years.[5,6]

Risk Factors for PTSD

Traumatic events are clearly very common, but not everyone who experiences a traumatic event develops PTSD. What risk factors, then, may predispose individuals to PTSD?

"From a primary-care perspective, it is important to know that the rates vary considerably from one trauma to another, although we have a mean of about 25%," observed Dr. Marshall. "For car accidents, the rate can be around a 10% risk, and for rape upwards of 50%."[7] In fact, one study of 51 rape victims found that 70% had PTSD.[8]

Risk is highest among victims of sexual assault, persons who participated in war or combat, and individuals who experienced the sudden and unexpected death of a loved one,[1,5] posited Terence M. Keane, PhD, who is Professor of Psychology and Psychiatry at Boston University School of Medicine, and Director of the National Center for Posttraumatic Stress Disorder at Veterans Administration Medical Center in Boston, Massachusetts. "Approximately 30% of people who are sexually assaulted go on to develop PTSD at some point in their lives, and that is probably a low estimate, frankly," stated Dr. Keane.[9] "In terms of combat or war the rates are somewhere between 30% and 40%.[10] If you think about war as an international issue, there are millions and millions of people today still exposed to wars. While the United States is generally a country at peace, many countries in Africa are certainly war-torn at the moment, and there are other places in the world that are at high risk for combat, war, and mass violence."

The risk of PTSD increases with greater frequency of trauma, occurrence of trauma during childhood, and perception of threat of death or injury during the trauma, added Edna B. Foa, PhD, who is Director of the Center for the Treatment and Study of Anxiety and Professor of Clinical Psychology in Psychiatry at the University of Pennsylvania in Philadelphia. She noted that a number of individual characteristics further increase risk, including history of psychiatric disorder predating the traumatic event, psychiatric hospitalization, a negative coping style, and persistent feelings of guilt or rage after the trauma.[1] Being female is also a risk factor.[1] "Women are twice as likely as men to get PTSD given the same type of trauma—with one exception, and that is rape," explained Dr. Foa. "Men who have been raped are slightly more likely to have PTSD than are women."[11,12]

"The individual risk factors may give you a two- to fourfold increase in risk, but none of these together let you predict with certainty who is going to get PTSD," cautioned Dr. Marshall. Furthermore, he noted that the severity of a trauma is likely to be more important than the personal risk factors, such that someone with a severe trauma and no other risk factors can still develop PTSD.

Diagnosis of PTSD

Dr. Marshall described PTSD as "a valid and reliably diagnosable entity," noting that although it was not officially recognized until 1980, "there is literature going back more than a century that portrays a kind of consensual description of the typical posttraumatic syndrome that one sees after trauma." According to Dr. Marshall, diagnosing PTSD "really comes down to a careful clinical assessment." He recommends using the diagnostic criteria from the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; **Table 1**),[13] which he says "has been shown to be an effective way of capturing at least the majority of people who have clinically important symptoms."

The *DSM-IV* criteria for PTSD require that the person repeatedly reexperience the traumatic event. "This can be in the form of thoughts or images or recurring distressing dreams," explained Dr. Marshall. "It could just be a thought that is quite upsetting or it could be a kind of dissociative experience in which the trama is being relived momentarily," he continued.

Another, probably even more important, criteria in terms of differentiating a clinical

syndrome from a normal reaction to a severe trauma is that the person must also exhibit avoidance. "You could boil down avoidance to three components," elaborated Dr. Marshall, "One would be an internal avoidance, meaning an attempt to push aside thoughts or feelings related to the trauma. The second could be an external avoidance, meaning a change in behavior to avoid being reminded of the trauma. And the third is a kind of emotional numbing in which there is a withdrawal from engagement in the world as well as a sort of muting of emotional response in general—not just to traumatic reminders."

Dr. Marshall noted that there is also a biological component to PTSD that includes increased autonomic arousal manifested by insomnia, irritability, outbursts of anger, difficulty concentrating, and exaggerated startled response. In addition, many persons with PTSD have "a general heightening of vigilance, a sense of caution that there may be trouble right around the corner," he added.

Primary-care physicians should also be aware that patients who have experienced trauma but do not meet the full criteria for PTSD may nonetheless have a considerable amount of disability. Dr. Marshall said that this is supported by recent data he has accumulated from a study of 9,000 individuals across the United States who were asked about symptoms of PTSD, as well as previous studies on the subject.[14,15]

Dr. Foa strongly agreed, noting, "The fact that some people do not meet the criteria for PTSD but are at the same time disabled or dysfunctional brings to the forefront the issue that our diagnostic criteria are a kind of *a la carte* menu where you have to have one of these, three of these, and two of this other group. As a research tool, it is very convenient because it allows us to all speak the same language. However, clinically, if you see a patient who has all five reexperiencing symptoms and all of the arousal

TABLE 1. Checklist of *DSM-IV* Diagnostic Criteria for PTSD

- ❑ Patient has been exposed to traumatic event that meets both of the following:
  - ❑ Actual or threatened death or serious injury, or threat to physical integrity of self or others
  - ❑ Feelings of fear, helplessness, or horror
- ❑ The patient meets at least one of the following criteria for reexperiencing the trauma:
  - ❑ Recurrent and distressing recollections or dreams of the event
  - ❑ Acting or feeling as if the event were recurring (sense of reliving, illusions, hallucinations, dissociative flashbacks)
  - ❑ Intense psychological distress or physiological reactivity at exposure to internal or external cues that symbolize or resemble an aspect of the event
- ❑ The patient has at least three of the following symptoms of persistent avoidance:
  - ❑ Efforts to avoid thoughts, feelings, or conversations associated with the trauma
  - ❑ Efforts to avoid activities, places, or people that arouse recollections of the trauma
  - ❑ Inability to recall an important aspect of the trauma
  - ❑ Markedly diminished interest or participation in significant activities
  - ❑ Feeling of detachment or estrangement from others
  - ❑ Restricted range of affect (e.g., unable to love)
  - ❑ Sense of a foreshortened future (e.g., does not expect to have career, marriage, children, or normal life span)
- ❑ The patient has at least two of the following persistent symptoms of increased arousal (not present before the trauma):
  - ❑ Difficulty falling or staying asleep
  - ❑ Irritability or outbursts of anger
  - ❑ Difficulty concentrating
  - ❑ Hypervigilance
  - ❑ Exaggerated startled response
- ❑ Duration of the disturbance is more than one month
- ❑ Disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Adapted from *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association; 1994:427-429.

symptoms but only two of the avoidance symptoms, saying that person does not meet criteria for PTSD is very arbitrary." Rather, she encouraged clinicians to consider the severity of the patient's symptoms in deciding whether the person is suffering from PTSD.

Taking this idea a step further, Dr. Keane contended, "It is also important to acknowledge that after traumatic events, a portion of people develop other kinds of disorders or conditions such as depression, phobia, or dissociative disorder." Dr. Doyle also added alcohol and drug abuse to this list.[16] Thus, Dr. Keane noted that the way reactions to traumas are expressed "is different from one person to another. PTSD is probably the most frequent outcome of exposure to a traumatic event, but it is not the only one."

Treatment of PTSD

Psychosocial Therapy

Exposure Therapy. "With PTSD, we are fortunate that we have more than one psychosocial treatment option," said Dr. Foa. "One could make the argument that the leader now is exposure therapy, which is not one therapy but a set of treatment programs. Common to all of them is the idea that you help patients confront their fear-evoking memories, situations, and objects, and by repeated confrontation you not only habituate the fear, but you also change cognitions that are associated with PTSD," she explained. The exposure therapy program that Dr. Foa developed involves nine to 12 sessions, held twice weekly for five weeks or once weekly for two to three months. Numerous studies have confirmed the efficacy of exposure therapy in PTSD.[17] In her own research, Dr. Foa reported that 85% of patients who underwent exposure therapy for PTSD showed a reduction in symptoms of more than 50% and maintained the improvement at follow-up.[17,18] About 20% of these patients were also taking medication for PTSD, but this was controlled for by not allowing initiation of new medication within three months prior to or during the study. All patients had PTSD symptoms at enrollment.

In classical exposure therapy, Dr. Keane explained, "what you're trying to do is to ask the person to construct the narrative of the traumatic memory. You ask about the details of the event or events in sequence. You have the person tell the story in as great detail as possible—the events, the sights, the sounds, the feels, the smells, and the person's thoughts and feelings." Then, continued Dr. Keane, "the story is repeated as many times as possible, first in the security of the therapy room and then as many times as possible outside the therapy room, so the person gets as much practice as possible in managing and mastering the images and thoughts and feelings associated with the traumatic event."

Dr. Foa also recommends audiotaping the story and having the patient listen to it as part of assigned homework.[18] "There are variations that we borrow from one program to another, but we know some things about what works in exposure therapy." For example, she offered, "We know that people who do not get engaged emotionally with the traumatic memory are not doing as well. How much emotional engagement you need to have is not clear, but you need to have some."[19,20] Conversely, she added, "We also make sure that patients do not get overwhelmed because we believe that when they get overwhelmed, they are not processing well and not learning that they are in control of the situation."

"This is so fundamental to the success of the treatment," agreed Dr. Keane. "The clinical judgment of an experienced therapist is really what titrates this emotional reaction. It's a difficult thing to teach people—what is too much and what is enough."

Dr. Marshall also finds exposure therapy difficult to teach to practitioners, but for a different reason. "Many times I get a negative reaction from clinicians because they say, 'Aren't you just retraumatizing patients by making them go back over the trauma?' It's crucial to appreciate that before you get to that point in the therapy, this treatment approach includes several sessions involving careful assessment, education, and provision of a rational model to the patient for why this would be helpful. What you're really trying to do is win the patient over to the idea that dealing with this trauma would be much more helpful than continuing to avoid it." He added that "the point is not reimmersion in the trauma for its own sake, but entirely for the goal of mastering the memory." Dr. Marshall noted that he sometimes explains to patients they will go over the trauma until it is no longer frightening and may even become boring. He says to them, "It's never going to be pleasant, but we don't want it to continue to be in your mind every day."

"We spend quite a bit of time on the rationale," agreed Dr. Foa. "If you give patients the rationale, you demonstrate to them how exposure is going to reduce the symptoms which is, after all, the goal of treatment." She tells patients that although being retraumatized is dangerous, memories of the traumatic event are not dangerous. By repeated reliving of the traumatic memories, the patients learn that remembering is not dangerous. Afterward, "they still would remember the trauma with sadness, but not necessarily with disruptive anxiety," she explained.

Other Forms of Psychotherapy. Dr. Foa explained that stress inoculation training and cognitive therapy are also effective treatments for PTSD,[18,21] if somewhat less effective than exposure therapy.[22] "Stress inoculation is a set of programs that teaches patients to manage their anxiety and stress better than they do. It includes relaxation training, breathing training, positive thoughts, and sometimes thought stopping techniques to help them control their intrusive thoughts. It usually also includes cognitive restructuring of some sort," she said. A few studies have also confirmed the efficacy of stress inoculation training in PTSD.[18,23]

Cognitive processing therapy, a specific program for rape victims that includes education, exposure via writing the traumatic event, and cognitive restructuring, is effective in reducing PTSD by helping patients deal with issues of trust, self-esteem, power, and safety, according to Dr. Foa.[21]

One of the most recent additions to the psychotherapeutic armamentarium for PTSD is eye movement desensitization and reprocessing (EMDR). This technique involves eliciting specific trauma memories and having the person think about those memories while following the side-to-side path of the therapist's fingers to produce bilateral visual stimulation. It attempts to develop alternative cognitive coping strategies, but "why this might change or alter the images or the thoughts about the traumatic event is completely up in the air," said Dr. Foa. "Several studies have examined the efficacy of EMDR and showed that it works," she said. "This approach to treating psychological trauma has really captured the imagination of practitioners internationally," she added. "The problem is that the studies were done in a rush. To do well-controlled studies, it takes about five years to collect the data to meet the requirements of good methodology." In one study, EMDR was ad-

"What you're really trying to do is win the patient over to the idea that dealing with this trauma would be much more helpful than continuing to avoid it."
—Dr. Marshall

ministered in four weekly sessions, after which patients were followed for three months. Patients treated with EMDR showed improved symptoms of PTSD and depression compared with untreated controls.[24] "Notwithstanding the methodological flaws of this and other studies, I think the therapy works," she concluded.

Dr. Keane commented that the EMDR approach is "a very interesting behavioral treatment strategy." He explained that EMDR is behavioral "because you are working directly on the traumatic memories or the traumatic symptoms. This is really at the heart of how behavior therapy developed 40 years ago, by direct treatment of symptoms." He further explained, "The idea is to arrive at an alternative way of viewing or experiencing the memories or the traumatic event and having that alternative carry forward outside the consulting room. To me, that is a very powerful strategy, but it is also something that many people have talked about in the past." Furthermore, in a review of EMDR, researchers from the National Crime Victims Research and Treatment Center reported that "there is no convincing evidence that eye movements significantly contribute to treatment outcome."[25]

"Some people would say that what works in EMDR is not new, and what's new doesn't work," acknowledged Dr. Foa. Furthermore, in one of the few comparative trials of EMDR, it was found to be less effective than a variant of cognitive-behavioral therapy called Trauma Treatment Protocol.[26]

Pharmacological Therapy

Dr. Marshall pointed out that "it is worthwhile for practitioners to take note of the history of pharmacological research in PTSD." Initially, it was assumed that because PTSD is caused by an environmental stressor, a psychological approach would be the only effective form of therapy. In the past decade especially, however, interest developed in the biological dysregulation involved in PTSD, according to Dr. Marshall. "There is a significant amount of animal research[27] pointing to very specific brain structures involved in mediating alarm, anxiety, and fear reaction responses to a threat in the environment. These strong biological reactions activate various noradrenergic systems, which appear to be modulated by serotonergic inputs among other pathways," he noted. Thus, Dr. Marshall added, "There is theoretical and now empirical evidence of a strong biological component to PTSD." He also cited a large twin study showing a genetic contribution of 20% to 30% for susceptibility to PTSD.[28]

Evidence of a biological component of PTSD provides a rationale for investigation of pharmacological therapy in this population. "Although data from large multicenter trials are still unpublished, the findings are that selective serotonin reuptake inhibitors [SSRIs] can be of moderate efficacy for chronic PTSD, even of many years' duration," noted Dr. Marshall.[29] In his own research in patients who have had PTSD for an average of nine years, approximately 10% to 30% of civilians were symptom-free following treatment, "which suggests that SSRIs can be quite helpful, but may not fully eliminate symptoms," he said. If primary-care physicians do decide to try a course of SSRIs for treatment of PTSD, he encouraged careful monitoring and referral of patients who continue to have symptoms.

Earlier trials have also shown benefit with monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs),[6,29] according to Dr. Marshall. MAOIs are difficult to use in primary care, he acknowledged, and more data are needed to support the use of TCAs. "Benzodiazepines are not recom-

mended for PTSD for several reasons," continued Dr. Marshall. "There are no trials showing efficacy,[30] and there is a very alarming study showing that they may prevent the natural processing of a traumatic event.[31] They may lower anxiety levels or reduce autonomic arousal, but this disorder is more complicated than just generalized anxiety," he elaborated.

"Many patients will have severe problems with sleep as part of their presenting symptoms. What specific suggestions do you have for primary-care physicians about managing that?" asked Dr. Doyle.

"Some unpublished SSRI studies have shown that hyperarousal, including insomnia, can be alleviated," replied Dr. Marshall. On the other hand, SSRIs can sometimes be very activating, he acknowledged. In the absence of empirical research on the issue, he recommended newer hypnotic agents such as zaleplon or zolpidem, because they do not have the same potential to produce dependency that occurs with benzodiazepines.

Dr. Doyle did not agree with this recommendation. "I'm suspicious about the new 'nonbenzodiazepine' hypnotics, especially as they get used for longer periods of time," he said.

Dr. Marshall emphasized the need for caution given that PTSD patients are at high risk for dependence. In one of Dr. Keane's studies, 60% to 80% of PTSD patients had concurrent diagnoses of substance abuse, alcohol abuse, or dependence.[16] "PTSD patients are in such distress, they self-medicate. That is why you might cause the patient new problems if you rush right in with a benzodiazepine." On the other hand, Dr. Marshall observed, "psychiatrists routinely use long-acting benzodiazepines like clonazepam for patients with severe panic, which is a common comorbidity. If there is a true clinical indication, we do not hesitate to use them."

"We run into trouble with how much time we can allocate at the primary-care setting to making fine gradations in diagnosing psychiatric disorders."

—Dr. Keane

PTSD in the Primary-Care Practice

"My concern about what's happening in the delivery of health care in America is that we are expecting primary-care providers to be specialists in everything and to do just about everything," lamented Dr. Keane. He said that in his own discussions with primary-care physicians he has noted an increasing level of frustration with all of the different performance monitors they are expected to complete in decreasing amounts of time with patients. In particular, he said, "We run into trouble with how much time we can allocate at the primary-care setting to making fine gradations in diagnosing psychiatric disorders." For example, he said, "The recognition that someone is depressed usually comes when someone says, 'I'm depressed.' That's an easy one, but there are many fine gradations of depression that require asking very specific questions. It's clear that depression is being evaluated and treated in primary-care settings, probably more so than in psychiatric settings, but there are questions remaining as to what the outcomes are of doing it that way. At least according to the data I've been seeing, primary-care providers are struggling to treat depression effectively." Dr. Keane added that PTSD is even more complicated than depression, "in part because we do not have a single medication or even a set of medications that appears to be effective across the board for people with PTSD, unlike depression, panic, or obsessive-compulsive disorder."

Ultimately, Dr. Keane advised primary-care physicians to identify patients who have experienced traumatic events and to determine whether such patients are having severe reactions to these events. He then recommended "creating an alliance with a mental health professional who is very familiar with PTSD to assist in managing such patients."

Even this much can be problematic for primary-care physicians, who "are not usually in a position to even ask about a trauma," acknowledged Dr. Foa. "So really, the question is, How can we identify PTSD? People don't come to the physician and say, 'Look, I was traumatized five years ago, and I still have flashbacks and nightmares.' " As a result, PTSD is underdiagnosed in the primary-care setting. "Neither the patients nor the physicians have been educated about PTSD," she lamented. She recommended that primary-care physicians add a question to their new-patient intake forms asking whether or not patients have ever experienced a trauma, and, if so, if they have any of the five or six major symptoms of PTSD. The follow-up inquiry, she said, is justified given the high incidence of traumatic events and PTSD. If the patient answers "yes" to these questions on the initial screen, the physician would refer to a full checklist of symptoms, such as the one provided in **Table 1**, to make the diagnosis.

"We've been thinking about studying this in the community, this idea of having a brief screen that asks about trauma and symptoms and then tries to provide a model to the physician for what to do," acknowledged Dr. Marshall. "Often these kinds of efforts still fail because physicians haven't been given the appropriate education and training as to what to do when they find someone with PTSD symptoms." Thus, he said, PTSD needs to "enter into the medical education system at the level of medical school training and residency." In the meantime, he said, "I think it would be a great idea to have a screen that would ask about 13 common traumas, like the National Comorbidity Study did,[5] and then ask screening questions, such as the type Naomi Breslau and others have developed recently.[32] These could be followed by some kind of exploration of the PTSD symptoms and then education about the disorder and treatment options."

Dr. Foa pointed out that to save physicians time, screening interviews can be performed by nurse practitioners or other designated personnel.

"Here in Boston we try to use computers with touch screens to evaluate these kinds of experiences," offered Dr. Keane. Irrespective of what strategy physicians select to identify patients with PTSD, Dr. Keane declared that, once diagnosed, these patients should be referred to mental health providers or specialty clinics. Specialty care, he argued, is required for managing PTSD because it takes considerable time, energy, and emotional investment to listen repeatedly to the stories of violence. Furthermore, he pointed out, "Arriving at collaborative arrangements with mental health service providers to work directly on PTSD and related traumatic conditions will do much to alleviate the patient burden for primary-care providers. We've seen in multiple studies across multiple patient populations that high users of primary-care services and medical services in general are people who have trauma histories and people who have PTSD."[1,4]

Dr. Marshall agreed with the need for specialty care. "This is difficult work even for highly trained mental health practitioners. It's extremely emotional for both the clinician and the patient, and you need a lot of practice at dealing with the whole sets of reactions that the patient and clinician have," he said. "I don't think we should throw primary-care providers out into the field to do these trauma assessments with no preparation, although I have met primary-care providers who are very interested in this kind of work and who have set up their practices so that they can do more in-depth inquiries very successfully."

"We would expect primary-care doctors to diagnose PTSD, give patients some educational information—which itself could be therapeutic, knowing about the disorder and its natural course—and then some preliminary recommendations about referral," summarized Dr. Doyle. (See Table 2.) Unfortunately, he noted, not all primary-care physicians have access to mental health specialists. In such cases, primary-care physicians may be forced

TABLE 2. Addressing and Treating PTSD in the Primary-Care Setting

- Identify PTSD in a patient who is anxious, depressed, or upset by asking specifically about trauma.
- Educate the patient about PTSD—this alone will significantly relieve the patient's distress.
- Once PTSD is identified, prescribe appropriate medication and direct the patient to a mental health professional with expertise in dealing with the clinical problems of PTSD.

to rely on medication and developing their own skills in psychotherapy.

In preparing guidelines for primary-care physicians regarding PTSD, the International Consensus Group on Depression and Anxiety also emphasized the importance of educating patients who have recently experienced trauma: "Primary-care physicians have an immediate educative role in explaining to victims that they will likely experience anxiety, depression, irritability, nightmares, and even flashbacks as part of the normal reaction to the stress of trauma. They should encourage patients to talk about the traumatic experience with their family or friends, stressing the importance of sharing their feelings with the people they trust. Physicians should also recognize that some victims will prefer to distance themselves from their experience and will not want to talk about it," wrote the International Consensus Group. Subsequently, according to the guidelines, "Education should continue with advice about short-term health behavior and avoidance of excessive use of alcohol, nicotine, or other drugs." The guidelines then call on primary-care physicians to provide initial psychosocial support and to evaluate the need for referral for specialty care.[6]

Final Thoughts

"PTSD is a disorder that is commonly underdiagnosed and undertreated in primary-care settings," emphasized Dr. Doyle. "There is clearly a role for the primary-care doctor in identifying and educating PTSD patients. Much can be done to direct them to treatments that have been proved effective."

Dr. Marshall agreed, suggesting that "from the primary-care perspective, the greatest service you could do your patients is to identify a potential posttraumatic stress reaction. The simplest way to do that would be to inquire specifically about typical traumas that lead to PTSD, and there are a number of questionnaires available that allow you to do that." He also prompted primary-care physicians to seek additional training or help in talking to patients about these traumas and providing hope that there are effective treatments available. With regard to management, he recommended, "Either begin with a medication if there are no other referral sources available or, preferably, refer the patient to a specialist who can do the much more time-consuming work that is necessary."

"We have medication that seems helpful, and we know what types of psychotherapies are helpful to PTSD," emphasized Dr. Foa. "The challenge is to educate physicians, mental health professionals, the public, and the potential patient who has PTSD. We need to launch educational programs like we did for panic disorder."

Dr. Keane stressed "how important it is for people to appreciate the prevalence of violence in our societies today and to understand that much of this violence goes on in people's homes. Asking questions about it," he concluded, "can yield a change in the trajectory of the life of an individual so questioned." ■

Guidelines and position statements on the diagnosis and management of posttraumatic stress disorder are provided for those physicians interested in more information about the issues debated in this month's **Medical Crossfire**. *Please see page 67.*

REFERENCES

1. Hidalgo RB, Davidson JRT. Posttraumatic stress disorder: epidemiology and health-related considerations. *J Clin Psychiatry*. 2000;61(suppl 7):5-13.

2. Davidson JR, Connor KM. Management of posttraumatic stress disorder: diagnostic and therapeutic issues. *J Clin Psychiatry*. 1999;60(suppl 18):32-38.

3. Helzer JE, Robins LN, McEvoy L. Posttraumatic stress disorder in the general population: findings of the Epidemiologic Catchment Area Survey. *N Engl J Med*. 1987;317:1630-1634.

4. Stein MB, McQuaid JR, Pedrelli P, et al. Posttraumatic stress disorder in the primary care medical setting. *Gen Hosp Psychiatry*. 2000;22:261-269.

5. Kessler RC, Sonnega A, Bromet E, et al. Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry*. 1995;52:1048-1060.

6. Ballenger JC, Davidson JR, Lecrubier Y, et al. Consensus statement on posttraumatic stress disorder from the International Consensus Group on Depression and Anxiety. *J Clin Psychiatry*. 2000;61(suppl 5):60-66.

7. Foa EB. Trauma and women: course, predictors, and treatment. *J Clin Psychiatry*. 1997;58(suppl 9):25-28.

8. Bownes IT, O'Gorman EC, Sayers A. Assault characteristics and posttraumatic stress disorder in rape victims. *Acta Psychiatr Scand*. 1991;83:27-30.

9. Resnick HS, Kilpatrick DG, Dansky BS, et al. Prevalence of civilian trauma and posttraumatic stress disorder in a representative national sample of women. *J Consult Clin Psychol*. 1993;61:984-991.

10. Kulka RA, Schlenger WE, Fairbank JA, et al. *Contractual Report of Findings from the National Vietnam Veterans Readjustment Study*. Research Triangle Park, NC: Research Triangle Institute; 1988.

11. Rothbaum BO, Foa EB, Riggs DS, et al. A prospective examination of post-traumatic stress disorder in rape victims. *J Trauma Stress*. 1992;5(3):455-475.

12. Kessler RA. Posttraumatic stress disorder: the burden to the individual and to society. *J Clin Psychiatry*. 2000;61(suppl 5):4-14.

13. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association; 1994:424-429.

14. Stein MB, Walker JR, Hazen AL, Forde DR. Full and partial posttraumatic stress disorder: findings from a community survey. *Am J Psychiatry*. 1997;154(8):1114-1119.

15. Marshall RD, Olfson M, Hellman F, et al. Comorbidity, impairment, and suicidality in subthreshhold PTSD. *Am J Psychiatry*. In press.

16. Keane TM, Gerardi RJ, Lyons JA, Wolfe J. The interrelationship of substance abuse and posttraumatic stress disorder. Epidemiological and clinical considerations. *Recent Dev Alcohol*. 1988;6:27-48.

17. Foa EB. Psychosocial treatment of posttraumatic stress disorder. *J Clin Psychiatry*. 2000;61(suppl 5):43-48.

18. Foa EB, Dancu CV, Hembree EA, et al. A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *J Consult Clin Psychol*. 1999;67:194-200.

19. Hembree EA, Foa EB. Posttraumatic stress disorder: psychological factors and psychosocial interventions. *J Clin Psychiatry*. 2000;61(suppl 7):33-39.

20. Foa EB, Riggs DS, Massie ED, Yarczower M. The impact of fear activation and anger on the efficacy of exposure treatment for PTSD. *Behavior Therapy*. 1995;26:487-499.

21. Resick PA, Schnicke MK. Cognitive processing therapy for sexual assault victims. *J Consult Clin Psychol*. 1992;60:748-756.

22. Marks I, Lovell K, Noshirvani H, et al. Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring. *Arch Gen Psychiatry*. 1998;55:317-325.

23. Foa EB, Rothbaum BO, Riggs DS, Murdock T. Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedure and counseling. *J Consult Clin Psychology*. 1991;59:715-723.

24. Rothbaum BO. A controlled study of eye movement desensitization and reprocessing in the treatment of post-traumatic stress disordered sexual assault victims. *Bull Menninger Clin*. 1997;61:317-334.

25. Cahill SP, Carrigan MH, Frueh BC. Does EMDR work? And if so, why?: a critical review of controlled outcome and dismantling research. *J Anxiety Disord*. 1999;13:5-33.

26. Devilly GJ, Spence SH. The relative efficacy and treatment distress of EMDR and a cognitive-behavior trauma treatment protocol in the amelioration of posttraumatic stress disorder. *J Anxiety Disord*. 1999;13:131-157.

27. Charney DS, Grillon CCG, Bremner JD. The neurobiological basis of anxiety and fear: circuits, mechanisms, and neurochemical interactions (Part II). *Neuroscientist*. 1998;4:122-132.

28. True WR, Rice J, Eisen SA, et al. A twin study of genetic and environmental contributions to liability for posttraumatic stress symptoms. *Arch Gen Psychiatry*. 1993;50:257-264.

29. Marshall RD, Pierre D. Implications of recent findings in posttraumatic stress disorder and role of pharmacotherapy. *Harv Rev Psychiatry*. 2000;7:247-256.

30. Braun P, Greenberg D, Dasberg H, Lerer B. Core symptoms of posttraumatic stress disorder unimproved by alprazolam treatment. *J Clin Psychiatry*. 1990;51:236-238.

31. Gelpin E, Bonne O, Peri T, et al. Treatment of recent trauma survivors with benzodiazepines: a prospective study. *J Clin Psychiatry*. 1996;57:390-394.

32. Breslau N, Peterson EL, Kessler RC, Schultz LR. Short screening scale for DSM-IV posttraumatic stress disorder. *Am J Psychiatry*. 2000;156(6):1026.

FAX RESPONSE

PEER EXCHANGE CONNECTIONS

FAX: Complete this form and fax it to our offices at **(732) 780-7595**
E-MAIL: E-mail your comments to **mdpeerx@medicalcrossfire.com**
TOLL-FREE VOICE MAIL: State your opinion at **(877) MDPEERX** (877-637-3379)

Featured debate you wish to comment on: _____

Peer Exchange Comments (Please print clearly or type; use an additional sheet if necessary.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What one question would you like to ask the panelists? _____

_____

_____

Recommended future debate topic: _____

Name _____ Specialty _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____ E-mail _____

Signature _____ Date _____

(Please include your phone number for editorial verification purposes only. Signature grants approval to publish peer exchange comments.)

☑ **YES,** I would like to continue my FREE subscription to ***Medical Crossfire.***